Coverage for: Individual/Family | Plan Type: PPO

**Madison County: Blue Dimensions** 

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-447-7828 or visit www.bcbsmt.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 person / \$4,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services with a <u>copay</u> , <u>prescription</u> <u>drugs</u> , <u>hospice</u> , well-child, and In-Network preventive health care and diagnostic mammograms are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive</u> services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$150 for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$4,000 person / \$8,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://www.bcbsmt.com">www.bcbsmt.com</a> or call 1-800-447-7828 for a list of participating <a href="providers">providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common		What You Will Pay		Limitationa Evacationa 9 Other
Medical Event	Services You May Need	Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$25 <u>copayment</u> /visit; <u>deductible</u> does not apply	35% coinsurance	None
	Specialist visit	\$25 <u>copayment</u> /visit; <u>deductible</u> does not apply	35% coinsurance	None
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/immunization	No Charge; deductible does not apply	35% coinsurance	Maximum of one electric breast pump per year. <u>Deductible</u> and <u>coinsurance</u> do not apply to the first \$70 for Out-of-Network routine mammograms. <u>Deductible</u> does not apply to Out-of-Network well child service.  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a to-t	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	Preauthorization may be required; see
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	your member guide* for details.

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsmt.com</u>.

Camman		What You Will Pay		Limitations Evacutions ? Other
Common Medical Event	Services You May Need	Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	Limitations, Exceptions, & Other Important Information
	Generic drugs	Value Retail: \$10 copayment Participating Retail: \$15 copayment Mail: \$20 copayment; deductible does not apply	Retail: \$15 <u>copayment;</u> <u>deductible</u> does not apply	Brand prescription drug deductible: \$150 person Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at an approved mail order pharmacy. Specialty drugs limited to a 30-day supply.  Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available.  All Out-of-Network prescriptions are subject to a 50% benefit reduction after the applicable copay/coinsurance.  Additional charge will not apply to any deductible or out-of-pocket amounts.
If you need drugs to treat your illness or condition  More information about prescription	Preferred brand drugs	Value Retail: \$40 copayment Participating Retail: \$50 copayment Mail: \$80 copayment	Retail: \$50 <u>copayment</u>	
drug coverage is available at www.bcbsmt.com/me mber/prescription-drug-plan-information/drug-lists.	rug coverage is vailable at www.bcbsmt.com/me hber/prescription-rug-plan-nformation/drug-	Value Retail: 60% up to a maximum of \$200/ prescription Participating Retail: 60% up to a maximum of \$250/ prescription Mail: 60% up to a maximum of \$400/prescription	Retail: 60% up to a maximum of \$250/ prescription	
	Specialty drugs	Formulary: \$100 copayment Non-Formulary: \$200 copayment	50% coinsurance	
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	Preauthorization may be required; see your member guide* for details.
outpatient surgery	Physician/surgeon fees	20% coinsurance	35% coinsurance	Outpatient Infusion Therapy see your member guide* for details.
	Emergency room care	\$100 <u>copayment</u> /visit; <u>deductible</u> does not apply	\$100 copayment/visit; deductible does not apply	Copayment waived if admitted.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non- emergency transportation; see your member guide* for details.
	Urgent care	\$25 <u>copayment</u> /visit; <u>deductible</u> does not apply	35% coinsurance	None

<sup>\*</sup> For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{www.bcbsmt.com}}$ .

Common	Common What You Will Pay		Limitations Exceptions & Other	
Medical Event	Services You May Need	Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Preauthorization required.
hospital stay	Physician/surgeon fees	20% coinsurance	35% coinsurance	
If you need mental health, behavioral health, or substance abuse	Outpatient services	\$25 <u>copayment</u> /office visits; <u>deductible</u> does not apply or 20% <u>coinsurance</u> for other outpatient services	35% <u>coinsurance</u>	Outpatient: <u>Preauthorization</u> may be required; see your member guide* for details.  Inpatient: <u>Preauthorization</u> required.
services	Inpatient services	20% coinsurance	35% <u>coinsurance</u>	Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	\$25 <u>copayment</u> /visit; <u>deductible</u> does not apply	35% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% <u>coinsurance</u>	
	Home health care	20% coinsurance	35% coinsurance	Preauthorization may be required.  180 visit maximum per benefit period.
	Rehabilitation services	20% coinsurance	35% coinsurance	Preauthorization may be required.
If you need help recovering or have other special health needs	Habilitation services	\$25 copayment/visit; deductible does not apply	35% coinsurance	No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older.
	Skilled nursing care	20% coinsurance	35% <u>coinsurance</u>	Preauthorization may be required. 60 days maximum per benefit period.
	Durable medical equipment	20% coinsurance	35% coinsurance	Preauthorization may be required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization may be required.

<sup>\*</sup> For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at  $\underline{\text{www.bcbsmt.com}}$ .

Common		What You Will Pay		Limitations Everytions 9 Other
Common Medical Event	Services You May Need	Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's eye exam	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

## **Excluded services & Other Covered Services:**

## Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery (except for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Dental care (Adult)

- Hearing aids
- Long-term care
- Private-duty nursing

- Routine eye care (Adult)
- Routine foot care (except for persons with comorbidities, such as diabetes)
- Weight loss programs

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

- Acupuncture (12 visit maximum per benefit period)
- Chiropractic care (10 visit maximum per benefit period)
- Infertility treatment (with the exception of in vitro fertilization and prescription medications)
- Non-emergency care when traveling outside the U.S.

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.bcbsmt.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the <u>plan</u> at 1-800-447-7828, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272,) or <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="https://www.tealthCare.gov">Marketplace</a>. For more information about the <a href="https://www.tealthCare.gov">Marketplace</a>, visit <a href="https://www.tealthCare.gov">www.tealthCare.gov</a> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-800-447-7828 the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform, or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit www.csi.mt.gov.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-447-7828.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-447-7828.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码1-800-447-7828.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-447-7828.

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

## **About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

## Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan</u> 's overall <u>deductible</u>	\$2,000
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

In this example, Peg would pay:

<b>Total Example Cost</b>	\$12,800

Cost Sharing		
Deductibles	\$2,000	
Copayments	\$0	
Coinsurance	\$2,000	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,060	

## **Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

**Total Example Cost** 

<u>Durable medical equipment</u> (glucose meter)

In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$2,000	
Copayments	\$1,100	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Joe would pay is	\$3,160	

# Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

\$7,400

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900

In this example, Mia would pay:

m une example, ma treata pay.	
Cost Sharing	
Deductibles	\$1,100
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 898-710-898.
ଧୃକ୍ଷାଧ୍ୟ Burmese	သင် သို့မဟုတ် သင်ကူညီပေးနေသူတဦးမှ မေးမြန်းလိုသည့် မေးခွန်းများရှိပါက သင့် ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များကို အခမဲ့ဖြင့်ရယူနိုင်သည့်အခင့်အရေးရှိပါသ ည်။ ဘာသာစကား ပြန်ဆိုသူနှင့် စကားပြောရန် သင့် အဖွဲ့ ဂင်ကဒ်၏ နောက်ကျောဇက်ပေါ် ရှိ သုံးစွဲသူ ဂန်ဆောင်မှု ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ။ အကယ်၍ သင်သည် အဖွဲ့ ဂင်တစ်ဦး မဟုတ်ခဲ့ပါက သို့မဟုတ် ကဒ် မရှိပါက 855- 710-6984 သို့ ခေါ်ဆိုပါ။
GWY Cherokee	haz, do ygt ө amspmey, corolmo, ha cap omy roposia do rozaa cu golama ewoy davy. omyz dapady colazpat, obabwob omyot oʻhgmy dolmspmy omy ppt gvp aao dihama sawit aama. Лро hbro љу, do dihama hooo љу, ombwos dapa 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有 會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprête, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Hmoob Hmong	Yog koj, los yog tej tus neeg uas koj pab ntawd muaj lus nug txog, koj muaj cai hais kom lawv pab muab cov ntaub ntawv sau ua koj hom lus pub dawb rau koj. Xav tham nrog ib tug kws txhais lus, hu rau tus nab npawb xovtooj pab cuam neeg qhua uas nyob sab tom qab ntawm koj daim npav tswv cuab. Yog koj tsis yog ib tug neeg tswv cuab, los yog koj tsis muaj npav, hu rau 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າ ໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígií, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'i' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígií bich'i' hodíílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígií ádingo koji' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، با کسی که شما به او کمک می کنید، سؤالی داشکه باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مکرجم شفاهی، با خدمات مشکری به شماره ای که در یشت کارت عضویت دارید، با شماره 898-710-858 تماس حاصل نمایید. در ج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 898-710-858 تماس حاصل نمایید.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے کو، آپ کو اپنی زبان میں منٹ مدد اور معلومات حاصل کرنے کا حق ہے۔ مکرجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی یشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے کو، 858-710-855 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

### Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator

300 E. Randolph St. 35th Floor

Chicago, Illinois 60601

Phone:

855-664-7270 (voicemail)

TTY/TDD: 855-661-6965 855-661-6960 Fax:

Email:

CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services

200 Independence Avenue SW Room 509F, HHH Building 1019

Washington, DC 20201

Phone:

800-368-1019

TTY/TDD:

800-537-7697 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html